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Arizona Health-e Connection

Executive Summary of Proposal for Statutory and Regulatory Amendments to Support Electronic Health Information Exchange in Arizona

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In 2007, the Arizona Health-e Connection Legal Working Group drafted proposals for legislative and regulatory changes where we identified laws that pose barriers to the implementation of e-health information exchange in Arizona. This Executive Summary describes our proposed amendments to statutes and regulations regarding communicable disease, mental health, immunization, and genetic testing information and subpoenas for medical records. Our proposal recommends ways to remove barriers to e-health information exchange, yet to continue to ensure privacy protection for individual health information. We recommend this proposed legislation for introduction in the 2009 legislative session, after consultation with all interested stakeholders and legislators.

The Legal Working Group is presently working on a project to draft a new statute or to amend existing statutes to create an enforcement mechanism to ensure the privacy and security of consumer information and to implement accountability for any inappropriate access to a health information exchange. We welcome involvement in this project. If interested, please contact Kim Snyder at ksnyder@azita.gov.

Executive Summary

The Arizona Health-e Connection Legal Working Group proposes the following revisions to laws that pose barriers to the implementation of e-health information exchange in Arizona:

(1) Communicable Diseases:
A.R.S. § 36-661 *et seq*., A.R.S. § 20-448.01 and A.A.C. R20-6-1204

In Arizona, communicable diseases include any disease that health care providers must report to the Arizona Department of Health Services (ADHS) or county health departments. These include a wide range of diseases, from HIV/AIDS to the simple flu.

A.R.S. § 36-663(H) contains a requirement that, if a disclosure of communicable disease information is made for a purpose for which an authorization is required, the disclosure must be accompanied by a statement "in writing that warns that the information is from confidential records protected by state law and that prohibits further disclosure of the information without the specific written authorization of the person to whom it pertains or as otherwise permitted by law." We recommend removing this requirement, because a requirement for a written statement regarding redisclosure will make electronic exchange of that information impossible. Moreover, we believe that removing this requirement will not reduce privacy protection,

because where communicable disease information is disclosed to a person pursuant to a patient's authorization, the person receiving the information also must comply with the statute.[1]

Next, the statute lists the purposes for which a health care provider may disclose communicable disease information without consent of the patient. We recommend adding a provision permitting disclosure through a health information exchange (HIE) mechanism, to clarify that an HIE will be permitted to receive and disclose communicable disease information on behalf of a health care provider. Because there is not a universally recognized definition for a "health information exchange," we propose to define it as an agent that conducts health information exchange, which can be broadly interpreted to fit the variety of HIEs developing. We also propose to limit the disclosure to agents that agree to limit disclosure to those purposes permitted by the statute, so that any communicable disease information transmitted continues to have downstream protection.

We also recommend amending A.R.S. § 20-448.01and A.A.C. R20-6-1204 so that insurers may disclose communicable disease information in the same manner as providers. We recommend retaining provisions essential to privacy protection, such as limitation of the type of information that may be released to an insurance medical information exchange (which we redefine for clarity to ensure that it does not cover an HIE) and in responses to subpoenas or court orders.

Finally, we will recommend to the Arizona Department of Health Services to remove the 180-day limit on authorizations for release of communicable disease information found in A.A.C. R20-6-1204, to make those authorizations consistent with other types of health information in Arizona.

(2) <u>Mental Health Information</u>:
A.R.S. § 36-501, *et seq*.

The Arizona mental health statutes, which apply to mental health care providers and health care institutions licensed as behavioral health providers, limit disclosure of mental health information without patient consent as expressly listed in the statute.

The statute permits health care providers to release mental health information to payors to obtain reimbursement, but not for utilization review, case management or disease management, all of which are permitted under the HIPAA Privacy Rule and may be essential for the management of patient care. We recommend adding those permitted disclosures.

We also recommend adding a provision permitting disclosure through an HIE mechanism, to clarify that an HIE will be permitted to receive and disclose mental health information on behalf of a health care provider.

[1] A.R.S. § 36-664(A).

(3) Immunization Information:
A.R.S. § 36-135 and A.A.C. R9-6-708

The Arizona laws restrict the purposes for which ADHS may release immunization data, which include to health care professionals, parents and guardians, and others. The law also contains substantial penalties if a health care professional or other person who receives immunization information from ADHS releases it to someone else.

We recommend removing this redisclosure prohibition, because this would prevent any immunization information received by a health care provider from ADHS to be re-disclosed to other health care providers, including through an HIE. Instead, we recommend providing that immunization information may be redisclosed only to those whom ADHS may release the information. This will continue to restrict who receives immunization information, but will not interfere with the exchange of immunization information for treatment and other permitted purposes.

We also recommend clarifying that disclosures to health plans are not restricted to AHCCCS and HMOs (but include all insurers regulated by Title 20), and permitting ADHS to release immunization information directly to an HIE on behalf of its participating health care providers.

(4) Genetic Testing Information:
A.R.S. § 12-2801, *et seq.* and A.R.S. § 20-448.02, *et seq.*

Arizona law contains significant restrictions on disclosure of genetic testing and information derived from genetic testing, due to the heightened concern with the potential for discrimination in insurance and employment due to genetic predisposition to a disease. On the other hand, genetic testing information is becoming increasingly significant information for diagnosis and effective treatment as the health care industry develops "personalized medicine"; information about the genetics of a particular cancer tumor or the ability to metabolize warfarin, for example, may make a significant difference in what treatment is provided to a particular patient. Moreover, the United States Congress is on the verge of enacting a federal Genetic Information Nondiscrimination Act.

We recommend that A.R.S. § 12-2801 be amended to clarify—and confirm the widespread understanding in Arizona—that "information derived from genetic testing" was not intended to cover diagnosis of a disease or treatment for a disease. We also recommend amending A.R.S. § 12-2802 to clarify that disclosures to treating providers are permitted.

The law provides that any person to whom genetic testing results have been disclosed shall not disclose the test results to any other person. This would prevent health care providers from releasing genetic testing information to another treating provider, or to an HIE on behalf of health care providers. We recommend removing this redisclosure prohibition and instead permit disclosures that otherwise are permitted under the statute, which will continue to protect genetic information. We also recommend permitting disclosures to an HIE on behalf of health care providers. Finally, we recommend amending the insurance statute, A.R.S. § 20-448.02, to permit disclosures in the same instances as A.R.S. § 12-2802.

(5) Medical Records Subpoena Statute
A.R.S. § 12-2294.01

The current medical records subpoena statute poses three potential barriers to health care providers' participation in an HIE if not clarified:

(1) Treatment of records from other sources: An increasing number of patients are presenting to hospitals and physicians with medical records from the patient's other health care providers, often stored on CDs or in other electronic form (such as personal health records). Moreover, providers will begin to have access to information through HIEs. The specific question presented is when records from other sources should be treated as the provider's own medical record in responding to subpoenas.

Right now, the definition of "medical records" in Arizona includes "all communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of patient diagnosis or treatment, including medical records that are prepared by a health care provider or by other providers." A.R.S. § 12-2291. We believe this definition is too broad and should instead reflect the industry standard. The industry standard, as reflected in guidance documents from the American Health Information Management Association, treats records from other providers as not being a part of the medical record produced in response to a subpoena unless the other providers' records are used by the responding provider in the provision of patient care. We thus propose a change in the definition of "medical record" in A.R.S. § 12-2291, to indicate that records from other sources are part of a provider's medical record only if they are used for the provision of patient care.

(2) Subpoenas issued to the HIE: The present medical records subpoena statute applies only to "health care providers" as defined above. It does not apply to HIEs or other third parties that hold medical records or payment records on behalf of health care providers. We recommend that the existing subpoena statute be extended to HIEs and others that hold records on behalf of health care providers, which would provide more protection for the privacy of the health information held or managed by an HIE.

(3) Depositions of Custodians of Record: We also suggest refining the subpoena statute to clarify when health care providers and HIEs must submit their custodians of record for a deposition. Hospitals and other health care providers long have followed the practice of providing copies of subpoenaed medical records with an affidavit from the custodian of records that the copy provided is a true and complete copy. Hospitals and other providers have followed that practice so that their custodians of records do not have to be deposed to establish the admissibility of the records produced. Unfortunately, hospitals have received notices of depositions of their custodian of records, even though they provided the affidavit to establish admissibility. This is a large resource commitment—providers are required to pay their employee to attend the deposition as well as a lawyer to represent the employee in the deposition—and this resource commitment is not necessary to establish admissibility of the records. We propose a formal process to submit an affidavit in support of records produced, as well as clarify that providers are not required to submit their custodian of records for deposition if they provide a compliant affidavit.

(6) **Adult Day Health Care Facility Regulations**
A.A.C. R9-10-511(C)

We recommend updating A.A.C. R9-10-511(C) to remove the requirement that adult day health care facilities to have medical records "recorded in ink."

(7) **Arizona Health Care Cost Containment System (AHCCCS) Regulations:**
A.R.S. § 36-2901 and A.A.C. R9-22-512

Working with AHCCCS, the Legal Working Group will continue to evaluate what statutory and regulatory restrictions apply to disclosures by AHCCCS and its AHCCCS contractors, providers, and noncontracting providers.

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